

08270

CERTIFICATE OF DEATH

08257

1. PLACE OF DEATH a. COUNTY Kent		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN lb 35 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kent & Queen Anne's Hospital		e. STREET ADDRESS 341 High Street	
3. NAME OF DECEASED (Type or print) First Middle Last Eleanor Mae Allen		4. DATE OF DEATH Month Day Year 6 20 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1920 12/31/1919
9. AGE (In years last birthday) 46 46 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 46 46 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME George Cornelius Barr		14. MOTHER'S MAIDEN NAME Ada MNM Northcraft	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 232-26-1404	
17. INFORMANT Hospital Records		Address Chestertown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary of liver DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			INTERVAL BETWEEN ONSET AND DEATH 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5/16 , 19 67 , to 6/20 , 19 67 , that (I) (we) last saw the deceased alive on 6/20 , 19 67 , and that death occurred at 10:10 P.M. , from causes and on the date stated above.			
22a. SIGNATURE A. C. Dick		22b. DATE SIGNED 6-21-67	
22c. PHYSICIAN'S NAME (Type) Dr. A. C. Dick		22d. ADDRESS Chestertown, Maryland 21620	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/23/1967	23c. NAME OF CEMETERY OR CREMATORY Johnstown Cem.	23d. LOCATION (City or Town) (County) (State) Earleville Cecil Co. Md.
24. FUNERAL DIRECTOR J. Willis Wells		25a. REC'D BY REGISTRAR DATE JUN 26 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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and go in 2nd

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/68

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08271

Item #2 From Birth Cert

CERTIFICATE OF DEATH

08258

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>New Jersey</u> b. COUNTY <u>Haddon Heights</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester town</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Haddon Heights</u> <u>673</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kent End Queen Anne's Hosp</u>				d. STREET ADDRESS <u>White Horse Pike</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Baby Boy</u> First Middle Last <u>DERATO</u>				4. DATE OF DEATH <u>June 27</u> 19 <u>67</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-26-67</u>	
9. AGE (In years last birthday) Yrs. <u>21</u>		IF UNDER 1 YEAR Months <u>21</u> Days <u>20</u>		IF UNDER 24 HRS. Hours <u>21</u> Min. <u>20</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Kent Co, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>FRANK James Derato</u>				14. MOTHER'S MAIDEN NAME <u>ROSE MARY NMN De MATINI</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MOTHER</u>		Address <u>White Horse Pike</u> <u>Haddon Hts. N.J.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturely</u> <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6-26</u> , 19 <u>67</u> , to <u>6-27</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6-26</u> 19 <u>67</u> , and that death occurred at <u>3:35A</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>A.C. Dick</u>				22b. DATE SIGNED <u>6-27-67</u>		22c. PHYSICIAN'S NAME (Type) <u>A.C. Dick</u>	
22d. ADDRESS <u>Chester town, Md</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>6/27/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Kent + Queen Anne's Hosp</u>		23d. LOCATION (City or town) (County) (State) <u>Chester town Kent Md.</u>	
24. FUNERAL DIRECTOR <u>R. W. Marin Administrator</u>				25a. REC'D BY REGISTRAR <u>JUN 30 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "received" and "check" are faintly visible.]

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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
08272					08259						
1. PLACE OF DEATH a. COUNTY					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE						
Kent					Md.						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)						
Chesterville.					Chesterville.						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)			First		Middle		Last		4. DATE OF DEATH		
LEONARD			A.		DURHAM.		June,		22, 19 67		
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
Male		White.		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		March, 22, 1887		80		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Ret. Farmer				Farming.		Md.			U.S.A.		
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
Benjamin Durham						Emma Feffer.					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No				213-24-1275		Mrs. Pauline Skinner,		Crumpton, Md. 21828			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Dilatation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Hypertension</u> (c) <u>General Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Frailty & General Atrophy</u>										INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>June 22, 1947</u> , 19 <u>50</u> , to <u>June 22, 1947</u> , that (I) (we) last saw the deceased alive on <u>June 22, 1947</u> , and that death occurred at <u>7 P.</u> M. from the causes and on the date stated above.											
22a. SIGNATURE <u>C.H. Metcalfe</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6/24/67</u>			
22c. PHYSICIAN'S NAME (Type) C.H. Metcalfe, M.D.						22d. ADDRESS Sudlersville, Md. 21668					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)			
Burial			June, 25, 1967		Crumpton Cemetery.			Crumpton, Q.A.Co; Md.			
24. FUNERAL DIRECTOR Edward Fellows & Son.						ADDRESS Millington, Md. 21651		25a. REC'D BY REGISTRAR DATE JUN 28 1967		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08273

CERTIFICATE OF DEATH

08260

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sudlersville</u> 17-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Kent & Queen Anne Hospital</u>		d. STREET ADDRESS <u>Rt. #1</u>	
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Bernard</u> Last <u>Gorton Jr.</u>		4. DATE OF DEATH Month <u>6</u> Day <u>10</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6</u> <u>5</u> <u>12</u> <u>55</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>machinist</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Rhode Island Mass.</u>	
13. FATHER'S NAME <u>Frank Bernard Gorton Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Harriett NMN Hannond</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u> <u>WWI</u>		16. SOCIAL SECURITY NO. <u>039-09-0120</u>	
17. INFORMANT <u>Mrs. Alice Gorton, Sudlersville, Md. 21668</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial decompensation</u> DUE TO (b) <u>Cor pulmonale</u> DUE TO (c) <u>chronic bronchitis & emphysema</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 yrs</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6-7</u> , 19 <u>67</u> , to <u>6-10</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6-9</u> , 19 <u>67</u> , and that death occurred at <u>8:30</u> A.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Harry P. Ross</u>		22b. DATE SIGNED <u>6-10-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Harry P. Ross</u>		22d. ADDRESS <u>Chestertown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 13, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Sudlersville Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Sudlersville, Q.A.Co; Md.</u>	
24. FUNERAL DIRECTOR <u>Edward Fellows</u>		25. REC'D BY REGISTRAR <u>JUN 14 1967</u>	
25a. ADDRESS <u>Millington Md. 21651</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MARYLAND STATE DEPARTMENT OF HEALTH

08274

CERTIFICATE OF DEATH

08261

1. PLACE OF DEATH a. COUNTY <u>Kent County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester town</u>		c. LENGTH OF STAY IN lb <u>1mo. & 1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Golts, Md</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kent & Queen Anne's Hospital</u>				d. STREET ADDRESS <u>Route #1</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Richard Bradford Johnson</u>				4. DATE OF DEATH Month <u>June</u> Day <u>3</u> Year <u>19 67</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-25-83</u>		9. AGE (In years last birthday) <u>84</u> yrs.	IF UNDER 1 YEAR Months <u>3</u> Days <u>19</u> Hours <u>67</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ret. farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Kent Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Anthony ? Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Laura ? Wooters Wooters</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-36-0378</u>		17. INFORMANT <u>Hospital records</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Second phase</u>							INTERVAL BETWEEN ONSET AND DEATH <u>31 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5-20</u> , 19 <u>67</u> , to <u>6-3</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6-3</u> , 19 <u>67</u> , and that death occurred at <u>10:25</u> PM, from causes and on the date stated above.							
22a. SIGNATURE <u>A.C. Bird</u>				22b. DATE SIGNED <u>6-5-67</u>		22c. PHYSICIAN'S NAME (Type) <u>A.C. Bird</u>	
22d. ADDRESS <u>Chester town, Md</u>				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June, 6, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Galena Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Galena, Kent Co; Md.</u>	
24. FUNERAL DIRECTOR <u>Edward L. H. Williams, Jr.</u>				25a. REC'D BY REGISTRAR <u>JUN 7 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
08275					08263					
1. PLACE OF DEATH a. COUNTY Kent					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Kent					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall			c. LENGTH OF STAY IN 1b MAYLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall R.D.#2					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hinchingham Farm					d. STREET ADDRESS Hinchingham Farm			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Emma First Middle Last B. Mackie					4. DATE OF DEATH June 16, 1967 19					
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/8/1876		9. AGE (In years last birthday) 90 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) West Chester, Pa.			12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Thomas O'Connell					14. MOTHER'S MAIDEN NAME Levinia Scott					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. (If give war or dates of service)		17. INFORMANT Mr. Frank H. Mackie, Jr. Rd., Wilm. (7)			Address 1103 DuPont		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio Vascular (c) Arterio Sclerosis & Anemia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH Unknown		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Aug 18, 1966, to June 16, 1967, that (I) (we) last saw the deceased alive on June 16, 1967, and that death occurred at 4 A.M. from the causes and on the date stated above.										
22a. SIGNATURE Norbert C. Nitsch					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 6/16/67		
22c. PHYSICIAN'S NAME (Type) Norbert C. Nitsch					22d. ADDRESS Rock Hall, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/19/67		23c. NAME OF CEMETERY OR CREMATORY Sharps Cemetery			23d. LOCATION (City, town or county) (State) Fairhill, Maryland			
24. FUNERAL DIRECTOR Albert G. McIlwain, Jr.					ADDRESS 2700 Wash. St. Del.		25a. REC'D BY REGISTRAR JUN 23 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

10-10-10



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08276

CERTIFICATE OF DEATH

08264

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Still Pond				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Still Pond			
c. LENGTH OF STAY IN 1b 15 years				d. STREET ADDRESS ---			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ---				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Clarence R. Nicholson				4. DATE OF DEATH Month Day Year June 6, 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Dec. 21 1889	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (County & State, or foreign country) Kent Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John B. Nicholson				14. MOTHER'S MAIDEN NAME Margaret S. Gardner			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W. I 216-56-1474		17. INFORMANT Oliver C. Nicholson		Address Still Pond, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4.21 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH several years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/29 , 19 66 , to 6/6 , 19 67 , that (I) (we) last saw the deceased alive on 6/6/67 19 67 , and that death occurred at 7:30 PM , from the causes and on the date stated above.							
22a. SIGNATURE <i>Robert W. Farr</i>				M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/8/67	
22c. PHYSICIAN'S NAME (Type) Robert W. Farr M.D.				22d. ADDRESS Chestertown, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-10-67		23c. NAME OF CEMETERY OR CREMATORY Still Pond Centy.		23d. LOCATION (City, town or county) (State) Still Pond, Kent Md.	
24. FUNERAL DIRECTOR Victor N. Kennedy				ADDRESS Still Pond, Md.		25a. REC'D BY REGISTRAR DATE JUN 9 1967	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

MEDICAL CERTIFICATION

100



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
08277 Item #9 Film #G309 6/20/67 08265											
1. PLACE OF DEATH a. COUNTY Kent MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Kent					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rock Hall				c. LENGTH OF STAY IN 1b 4 years		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rock Hall					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Chesapeake St.						d. STREET ADDRESS Chesapeake St.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Harry C. Post						4. DATE OF DEATH Month Day Year June 14, 1967 19					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 22, 1894		9. AGE (in years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Boilmaker				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Virginia			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME don't know						14. MOTHER'S MAIDEN NAME don't know					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes WW 1				16. SOCIAL SECURITY NO. 184 10 6477		17. INFORMANT Margaret Post		Address: Chesapeake St. Rock Hall, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebro-vascular accident</i> IX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <i>Arteriosclerosis</i> DUE TO (c) <i>old age</i>										INTERVAL BETWEEN ONSET AND DEATH —	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 10-7-5- 1964, to 6-10-1967, that (I) (we) last saw the deceased alive on 6-10-1967, and that death occurred at 3A M, from the causes and on the date stated above.											
22a. SIGNATURE <i>Rudolf Eglitis</i>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/14/67			
22c. PHYSICIAN'S NAME (Type) Rudolf Eglitis						22d. ADDRESS Rock Hall, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 6/15/67		23c. NAME OF CEMETERY OR CREMATORY Silverbrook Crematory				23d. LOCATION (City, town or county) (State) Wilmington, Del.			
24. FUNERAL DIRECTOR <i>J. Willis Wells</i>						ADDRESS Chestertown, Md.		25a. REC'D BY REGISTRAR DATE JUN 16 1967		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	

08278

CERTIFICATE OF DEATH

08266

1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown c. LENGTH OF STAY IN 1b 20 hrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kent & Queen Anne's Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Betterton d. STREET ADDRESS --- e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Nancy Maxwell Price		4. DATE OF DEATH Month 6 Day 17 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 25, 1885
9. AGE (In years last birthday) yrs 82		10. IF UNDER 1 YEAR Months Days Hours Min. 17	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Owner		10b. KIND OF BUSINESS OR INDUSTRY Agriculture	
11. BIRTHPLACE (County & State, or foreign country) Kent Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Henry Price		14. MOTHER'S MAIDEN NAME Mary Catherine Baker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 217-36-0050	
17. INFORMANT Mrs. Alexander Schreiber		Address Chesapeake City, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebrovascular accident DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis (c) Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 17 hours years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6-16 , 19 67 , to 6-17 , 19 67 that (I) (we) last saw the deceased alive on 6-16 , 19 67 , and that death occurred at 4:30 M, from causes and on the date stated above.			
22a. SIGNATURE Dr. Dick		22b. DATE SIGNED 6-17-67	
22c. PHYSICIAN'S NAME (Type) Dr. Dick		22d. ADDRESS Chestertown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 6-19-67	23c. NAME OF CEMETERY OR CREMATORY I. U. Cemetery	23d. LOCATION (City or Town) (County) (State) Worton, Kent Md.
24. FUNERAL DIRECTOR Victor H. Kennedy		25a. REC'D BY REGISTRAR June 20 1967	
ADDRESS Still Pond, Md.		25b. REGISTRAR'S SIGNATURE James J. Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08279

08267

1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Massey Rural c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Md. f. COUNTY Kent. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Massey, d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First S. Middle ALDRICH Last PRICE.			4. DATE OF DEATH Month June Day 11 Year 1967				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH February, 8, 1886		9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months 11 Days 11 Hours 11 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (County & State, or foreign country) Md.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Edgar Thomas Price.		14. MOTHER'S MAIDEN NAME Anna Bennett.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address Mrs. Ola Price. Massey, Md. 21650			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bacterial pneumonia DUE TO (b) Cerebral hemorrhage DUE TO (c) Hypertension CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH 3 days 2 months 1 year?		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from 9.16 , 19 66 , to 6.11 , 19 67 , that (I) (we) last saw the deceased alive on 6.10 , 19 67 , and that death occurred at 12.4 M, from the causes and on the date stated above.							
22a. SIGNATURE Geza Koralewski				22b. DATE SIGNED 6.12.67			
22c. PHYSICIAN'S NAME (Type) Geza Koralewski, M.D.				22d. ADDRESS Millington, Md. 21651			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June, 15, 1967		23c. NAME OF CEMETERY OR CREMATORY Hickory Grove Cemetery.			
23d. LOCATION (City, town or county) Port Penn,		(State) Del.		24. FUNERAL DIRECTOR Edward Fellows,			
ADDRESS Millington, Md. 21651		25a. REC'D BY REGISTRAR JUN 14 1967		25b. REGISTRAR'S SIGNATURE James J. ...			

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08280

CERTIFICATE OF DEATH

08268

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown c. LENGTH OF STAY IN lb 5 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kent & Queen Anne's Hospital		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Still Pond, d. STREET ADDRESS — e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Myra Middle Katherine Last Roseberry		4 DATE OF DEATH Month June Day 30 Year 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH -02-28-1878
9 AGE (In years last birthday) yrs 89		10 UNDER 1 YEAR Months — Days — Hours — Min —	11 UNDER 24 HRS Months — Days — Hours — Min —
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARM OWNER		10b KIND OF BUSINESS OR INDUSTRY AGRICULTURE	
11 BIRTHPLACE (County & State, or foreign country) Maryland - Kent Co.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Hamilton Crew		14 MOTHER'S MAIDEN NAME Sarah Harris	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 219-36-7213	
17 INFORMANT Hospital Records		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arterio-sclerotic Cardiovascular Disease 4001 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of Cecum		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. —	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6/25 , 19 67 , to 6/30 , 19 67 , that (I) (we) last saw the deceased alive on 6-30 , 19 67 , and that death occurred at 3:05AM , from causes and on the date stated above.			
22a SIGNATURE Dr. Arthur T. Keefe M.D.		22b DATE SIGNED 6-30-67	
22c PHYSICIAN'S NAME (Type) Dr. Arthur T. Keefe		22d ADDRESS Chestertown, Maryland	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b DATE THEREOF 7-2-67	23c NAME OF CEMETERY OR CREMATORY STILL POND CEMTY	23d LOCATION (City or Town) (County) (State) STILL POND KENT MD.
24 FUNERAL DIRECTOR VICTOR N. KENNEDY		25a REC'D BY REGISTRAR STILL POND, MD.	
25b REGISTRAR'S SIGNATURE J. Charles Judge		DATE JUL 3 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
2DM 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
08281						08269					
1. PLACE OF DEATH a. COUNTY <u>Kent</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Kent + Queen Anne Hosp</u>						d. STREET ADDRESS <u>835 W High St.</u>					
3. NAME OF DECEASED (Type or print) First <u>Adelle</u> Middle <u>Francis</u> Last <u>Townsend</u>						4. DATE OF DEATH Month <u>June</u> Day <u>13</u> Year <u>1967</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 8 1891</u>		9. AGE (in years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Kent Co Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Washington Trithman</u>						14. MOTHER'S MAIDEN NAME <u>Elizabeth Money</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)						16. SOCIAL SECURITY NO. <u>218-34-8434</u>		17. INFORMANT <u>Mr. Clifton Townsend</u> Address <u>835 W High St. Chestertown Md</u>			
18. CAUSE OF DEATH [Enter only one cause, per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary failure (C.P.S.)</u> 43X DUE TO (b) <u>Arterio-sclerotic hypertensive heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
INTERVAL BETWEEN ONSET AND DEATH <u>Over 2 years</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>4-24</u> , 19 <u>65</u> , to <u>6-13</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6-13</u> , 19 <u>67</u> , and that death occurred at <u>1:57</u> AM, from the causes and on the date stated above.											
22a. SIGNATURE <u>A.C. Dick</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6-13-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>A.C. Dick</u>						22d. ADDRESS <u>Chestertown, Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>June 15, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Chester Am.</u>		23d. LOCATION (City, town or county) (State) <u>Chestertown Kent Co. Md.</u>					
24. FUNERAL DIRECTOR <u>Wm. V. Wellham</u> ADDRESS <u>Chestertown Md.</u>						25a. REC'D BY REGISTRAR <u>JUN 16 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08282

08270

1. PLACE OF DEATH a. COUNTY KENT b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) MILLINGTON - RURAL c. LENGTH OF STAY IN 1b 3 weeks d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) _____				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND b. COUNTY QUEEN ANNES c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) GREENSVILLE - 17 d. STREET ADDRESS None e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First OSCAR Middle _____ Last TRICE				4. DATE OF DEATH 6-11-67 19 67			
5. SEX MALE		6. COLOR OR RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-1-86 80 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm laborer		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Solomon Trice				14. MOTHER'S MAIDEN NAME No Record			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Edgar Trice, Queen Anne's Co., Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) KNOWN HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO (c) BLIND, CACHECTIC, DEHYDRATED ETC ON EXAM DR. LIBBY 7/1/67						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE O. S. Gulbrandson		22. DATE SIGNED 6-11-67					
EXAMINER'S NAME (Type) O. S. GULBRANDSON, MD.		M.O. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Admng Address (Street, city, town, or county) KENT					
23a. BURIAL, CREMATION, or REMOVAL (Specify) Buried		23b. DATE THEREOF 6-15-67		23c. NAME OF CEMETERY OR CREMATORY Union		23d. LOCATION (City, town or county) (State) Goldboro, Md.	
24. FUNERAL DIRECTOR J. E. Boulaire		ADDRESS Greensboro, Md.		25a. REC'D BY REGISTRAR JUN 14 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. FOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
08283					Reg. Dist. 08271					
1. PLACE OF DEATH a. COUNTY Kent MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kennedyville			c. LENGTH OF STAY IN TB 2 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Betterton					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ---					d. STREET ADDRESS ---			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Joseph Middle Walter Last Webb					4. DATE OF DEATH Month June Day 13 , Year 1967					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 18, 1949		9. AGE (In years last birthday) 17 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY school		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Joseph J. Webb					14. MOTHER'S MAIDEN NAME Mildred Alene Woodall					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Joseph J. Webb			Address Betterton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Epilepsy 3533 DUE TO Has had epilepsy for many years and has been under treatment at the Kent County Health Dept. Seizure clinic. Felt badly all day 6/13/67. Had been having increased seizures for several weeks despite changes & increases of medication. Had 2 seizures in rapid succession P.M. of 6/13/67. Died following the last, at about 8:20 P.M. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour e. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE Robert W. Farr		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 6/15/67								
EXAMINER'S NAME (Type) Robert W. Farr, M. D.										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-16-67		22c. NAME OF CEMETERY OR CREMATORY Still Pond Cemty.		22d. LOCATION (City, town, or county) (State) Still Pond Maryland				
23. FUNERAL DIRECTOR'S SIGNATURE Victor N. Kennedy					ADDRESS Still Pond, Md.		24a. REC'D BY REGISTRAR DATE JUN 16 1967		24b. REGISTRAR'S SIGNATURE James Judge	

